Medicaid Disability Manual

11.00 Neurological - Adult

A. *Epilepsy*. In epilepsy, regardless of etiology, degree of impairment will be determined according to type, frequency, duration, and sequelae of seizures. At least one detailed description of a typical seizure is required. Such description includes the presence or absence of aura, tongue bites, sphincter control, injuries associated with the attack, and postictal phenomena. The reporting physician should indicate the extent to which description of seizures reflects his own observations and the source of ancillary information. Testimony of persons other than the claimant is essential for description of type and frequency of seizures if professional observation is not available.

Under 11.02 and 11.03, the criteria can be applied only if the impairment persists despite the fact that the individual is following prescribed antiepileptic treatment. Adherence to prescribed antiepileptic therapy can ordinarily be determined from objective clinical findings in the report of the physician currently providing treatment for epilepsy. Determination of blood levels of phenytoin sodium or other antiepileptic drugs may serve to indicate whether the prescribed medication is being taken. When seizures are occurring at the frequency stated in 11.02 or 11.03, evaluation of the severity of the impairment must include consideration of the serum drug levels.

Should serum drug levels appear therapeutically inadequate, consideration should be given as to whether this is caused by individual idiosyncrasy in absorption or metabolism of the drug. Blood drug levels should be evaluated in conjunction with all other evidence to determine the extent of compliance. When the reported blood drug levels are low, therefore, the information obtained from the treating source should include the physician's statement as to why the levels are low and the results of any relevant diagnostic studies concerning the blood levels. Where adequate seizure control is obtained only with unusually large doses, the possibility of impairment resulting from the side effects of this medication must also be assessed. Where documentation shows that use of alcohol or drugs affects adherence to prescribed therapy or may play a part in the precipitation of seizures, this must also be considered in the overall assessment of impairment level.

B. Brain tumors. We evaluate malignant brain tumors under the criteria in 13.13. For benign brain tumors, we determine the severity and duration of the impairment on the basis of symptoms, signs, and laboratory findings (11.05).

C. *Persistent disorganization of motor function* in the form of paresis or paralysis, tremor or other involuntary movements, ataxia and sensory disturbances (any or all of which may be due to cerebral, cerebellar, brain stem, spinal cord, or peripheral nerve dysfunction) which occur singly or in various combinations, frequently provides the sole or partial basis for decision in cases of neurological impairment. The assessment of impairment depends on the degree of interference with locomotion and/or interference with the use of fingers, hands and arms.

D. *In conditions which are episodic in character*, such as multiple sclerosis or myasthenia gravis, consideration should be given to frequency and duration of exacerbations, length of remissions, and permanent residuals.

E. *Multiple sclerosis.* The major criteria for evaluating impairment caused by multiple sclerosis are discussed in Listing 11.09. Paragraph A provides criteria for evaluating disorganization of motor function and gives reference to 11.04B (11.04B then refers to 11.00C). Paragraph B provides references to other listings for evaluating visual or mental impairments caused by multiple sclerosis. Paragraph C provides criteria for evaluating the impairment of individuals who do not have muscle weakness or other significant disorganization of motor function at rest, but who do develop muscle weakness on activity as a result of fatigue.

Use of the criteria in 11.09C is dependent upon (1) documenting a diagnosis of multiple sclerosis, (2) obtaining a description of fatigue considered to be characteristic of multiple sclerosis, and (3) obtaining evidence that the system has actually become fatigued. The evaluation of the magnitude of the impairment must consider the degree of exercise and the severity of the resulting muscle weakness.

The criteria in 11.09C deal with motor abnormalities which occur on activity. If the disorganization of motor function is present at rest, paragraph A must be used, taking into account any further increase in muscle weakness resulting from activity.

Sensory abnormalities may occur, particularly involving central visual acuity. The decrease in visual acuity may occur after brief attempts at activity involving near vision, such as reading. This decrease in visual acuity may not persist when the specific activity is terminated, as with rest, but is predictably reproduced with resumption of the activity. The impairment of central visual acuity in these cases should be evaluated under the criteria in Listing 2.02, taking into account the fact that the decrease in visual acuity will wax and wane.

Clarification of the evidence regarding central nervous system dysfunction responsible for the symptoms may require supporting technical evidence of functional impairment such as evoked response tests during exercise.

F. *Traumatic brain injury (TBI).* The guidelines for evaluating impairments caused by cerebral trauma are contained in 11.18. Listing 11.18 states that cerebral trauma is to be evaluated under 11.02, 11.03, 11.04, and 12.02, as applicable.

TBI may result in neurological and mental impairments with a wide variety of posttraumatic symptoms and signs. The rate and extent of recovery can be highly variable and the long-term outcome may be difficult to predict in the first few months post-injury. Generally, the neurological impairment (s) will stabilize more rapidly than any mental impairment (s). Sometimes a mental impairment may appear to improve immediately following TBI and then worsen, or, conversely, it may appear much worse initially but improve after a few months. Therefore, the mental findings immediately following TBI

may not reflect the actual severity of your mental impairment (s). The actual severity of a mental impairment may not become apparent until 6 months post-injury.

In some cases, evidence of a profound neurological impairment is sufficient to permit a finding of disability within 3 months post-injury. If a finding of disability within 3 months post-injury is not possible based on any neurological impairment (s), we will defer adjudication of the claim until we obtain evidence of your neurological or mental impairments at least 3 months post-injury. If a finding of disability still is not possible at that time, we will again defer adjudication of the claim until we obtain evidence at least 6 months post-injury. At that time, we will fully evaluate any neurological and mental impairments and adjudicate the claim.

G. Amyotrophic Lateral Sclerosis (ALS).

1. Amyotrophic lateral sclerosis (ALS), sometimes called Lou Gehrig's disease, is a progressive, invariably fatal neurological disease that attacks the nerve cells (motor neurons) responsible for controlling voluntary muscles. Eventually, all muscles under voluntary control are affected, and individuals with ALS ultimately lose their ability to move their arms and legs, and their capacity to swallow, speak, and breathe. Most people with ALS die from respiratory failure. There is currently no cure for ALS, and most treatments are designed only to relieve symptoms and improve the quality of life.

2. Diagnosis of ALS is based on history, neurological findings consistent with the diagnosis of ALS, and electrophysiological and neuroimaging testing to rule out other impairments that may cause similar signs and symptoms. The diagnosis may also be supported by electrophysiological studies (electromyography or nerve conduction studies), but these tests may be negative or only suggestive of the diagnosis. There is no single test that establishes the existence of ALS.

3. For purposes of 11.10, documentation of the diagnosis must be by generally accepted methods consistent with the prevailing state of medical knowledge and clinical practice. The evidence should include documentation of a clinically appropriate medical history, neurological findings consistent with the diagnosis of ALS, and the results of any electrophysiological and neuroimaging testing.

11.01 Category of Impairments, Neurological

11.02 ***Epilepsy - convulsive epilepsy, (grand mal or psychomotor), documented by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once a month, in spite of at least 3 months of prescribed treatment.*** With:

A. Daytime episodes (loss of consciousness and convulsive seizures) or

B. Nocturnal episodes manifesting residuals which interfere significantly with activity during the day.

11.03 ***Epilepsy - nonconvulsive epilepsy (petit mal, psychomotor, or focal), documented by detailed description of a typical seizure pattern including all associated phenomena, occurring more frequently than once weekly in spite of at least 3 months of prescribed treatment.*** With alteration of awareness or loss of consciousness and transient postictal manifestations of unconventional behavior or significant interference with activity during the day.

11.04 ***Central nervous system vascular accident.*** With one of the following more than 3 months post-vascular accident:

A. Sensory or motor aphasia resulting in ineffective speech or communication; or

B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C).

11.05 Benign brain tumors
Evaluate under 11.02, 11.03, 11.04 or the criteria of the affected body system.

11.06 ***Parkinsonian syndrome*** with the following signs: Significant rigidity, bradykinesia, or tremor in two extremities, which, singly or in combination, result in sustained disturbance of gross and dexterous movements, or gait and station.

11.07 ***Cerebral palsy***. With:

A. IQ of 70 or less; or

B. Abnormal behavior patterns, such as destructiveness or emotional instability; or

C. Significant interference in communication due to speech, hearing, or visual defect; or

D. Disorganization of motor function as described in 11.04B.

11.08 ***Spinal cord or nerve root lesions, due to any cause*** with disorganization of motor function as described in 11.04B.

11.09 ***Multiple sclerosis***. With:

A. Disorganization of motor function as described in 11.04B; or

B. Visual or mental impairment as described under the criteria in 2.02, 2.03, 2.04, or 12.02; or

C. Significant, reproducible fatigue of motor function with substantial muscle weakness on repetitive activity, demonstrated on physical examination, resulting from neurological

dysfunction in areas of the central nervous system known to be pathologically involved by the multiple sclerosis process.

11.10 ***Amyotrophic lateral sclerosis***. With:

Amyotrophic lateral sclerosis established by clinical and laboratory findings, as described in 11.00G.

11.11 ***Anterior poliomyelitis***. With:

A. Persistent difficulty with swallowing or breathing; or

B. Unintelligible speech; or

C. Disorganization of motor function as described in 11.04B.

11.12 ***Myasthenia gravis***. With:

A. Significant difficulty with speaking, swallowing, or breathing while on prescribed therapy; or

B. Significant motor weakness of muscles of extremities on repetitive activity against resistance while on prescribed therapy.

11.13 ***Muscular dystrophy*** with disorganization of motor function as described in 11.04B.

11.14 ***Peripheral neuropathies***. With disorganization of motor function as described in 11.04B, in spite of prescribed treatment.

11.15 [Reserved.]

11.16 ***Subacute combined cord degeneration (pernicious anemia) with disorganization of motor function as described in 11.04B, not significantly improved by prescribed treatment***.

11.17 ***Degenerative disease not listed elsewhere, such as Huntington's Chorea, Friedreich's ataxia, and spino-cerebellar degeneration*****.** With:

A. Disorganization of motor function as described in 11.04B; or

B. Chronic brain syndrome. Evaluate under 12.02.

11.18 ***Cerebral trauma*****.**

Evaluate under the provisions of 11.02, 11.03, 11.04, and 12.02, as applicable.

11.19 ***Syringomyelia***. With:

A. Significant bulbar signs; or

B. Disorganization of motor function as described in 11.04B.